Checklist for Registration of an Out of Institution Birth

Please utilize the following checklist to document evidence for all births occurring outside of an institution. Evidence from section 1, section 2, and either section 3 or 4 must be presented to completely fulfill the requirements of Rule 3701-5-16.

Section 1: Evidence of Pregnancy
Please select one (1) that applies and attach supporting documentation to this list:

☐ A prenatal record or postnatal medical record consistent with the date of delivery, **OR**

☐ A statement from a physician or other health care provider (e.g., a registered nurse, nurse practitioner, public health nurse, licensed midwife, or EMS employee) qualified to determine pregnancy. Statement shall include mother's name, mother's date of birth, date of health exam, provider's signature, provider's printed name, signature date, and license number, **OR**

☐ A home visit exam by a public health nurse or other health care provider, **OR**

☐ _____other evidence as accepted by the State Registrar
(Please see listing on page 4 or use form on page 5) *

Section 2: Evidence that the infant was born alive.
Please select one (1) that applies and attach supporting documentation to this list:

☐ A statement from the physician or other health care provider who saw or examined the infant, **OR**

☐ An observation of the infant during a home visit by a public health nurse or health care provider, **OR**

☐ _____other evidence as accepted by the State Registrar
(Please see listing on page 4 or use form on page 5) *

Section 3: Evidence of the mother's presence in Ohio and proof of residence.
If the birth occurred outside of the mother's place of residence, please skip Section 3 and provide documentation for Section 4. Please select one (1) that applies and attach supporting documentation to this list:

☐ A valid driver's license, or a state issued identification card, which includes the mother's current residence on the face of the license or card, **OR**

☐ A recent rent receipt of any type of utility, telephone or other bill that includes the mother's name and address, **OR**

☐ A social service record at the time of the child's birth if the mother was receiving public assistance (e.g. WIC, food stamps, child support record), **OR**

☐ A recent bank statement that includes the mother's name and address, **OR**

☐ _____other evidence as accepted by the State Registrar.
(Please see listing on page 4) *

Section 4: Evidence that the birth occurred outside of the mother's place of residence and proof of residence. *If Section 3 has been completed, skip this section.* Please complete Part A, select one option from Part B, and attach supporting documentation to this request:

☐ **(A)** An affidavit from the property owner of the premises where the birth occurred that the mother was present on those premises at the time of the birth (See page 6 for affidavit form)

AND

☐ **(B)** A valid driver's license, or a state issued identification card, which includes the affiant's current residence on the face of the license or card, **OR**

☐ A rent receipt of any type of utility, telephone or other bill that includes the affiant's name and address, **OR**

☐ A social service record at the time of the child's birth if the affiant was receiving public assistance (e.g. WIC, food stamps, child support record), **OR**

☐ A bank statement that includes the affiant's name and address, **OR**

☐ _____other evidence as accepted by the state registrar,

Please Note: At the discretion of the State Registrar, additional evidence may be required to verify the facts of birth. If the required evidence is not available and the Local Registrar is not able to verify the facts of birth, the out of institution birth may be registered only by a court of competent jurisdiction.

EXAMPLES OF ACCEPTABLE DOCUMENTATION

The following list is provided as examples only and does not constitute a comprehensive list of all acceptable or non-acceptable forms of documentation. As Vital Statistics identifies more illustrative examples, we will update this list. Please black out any sensitive information (e.g. SSN, account number, etc.) before faxing the information to VS.

Section One – Proof of Pregnancy:

Acceptable:

- Statement by a physician, licensed nurse, chiropractor, dentist or other licensed health care professional who has firsthand knowledge of this pregnancy and is willing to attest to that fact even if did not provide direct treatment and who is not an immediate family member.
- Statement by a Certified Professional Midwife (CPM) who submits a copy of current and valid certificate from the North American Registry of Midwives (NARM) that establishes their credentials as a CPM. Please make sure to check 'Other' (last option) in the checklist.
- Statement by a midwife who submits a copy of their "Certificate of Authorization" with the signature of the State Registrar. (see page 5 for "pregnancy verification" form)

Non-acceptable:

- Statement by the husband or the mother even if licensed health care professional.
- Statement from any other person that does not fall within the licensed health care professional category, the CPM, or the authorized midwife.

Section Two – Proof of Live Birth

Acceptable:

- Statement by a physician, licensed nurse, chiropractor, dentist or other licensed health care professional who has firsthand knowledge of the live birth and is willing to attest to that fact even if did not provide direct treatment and who is not an immediate family member.
- Statement by a Certified Professional Midwife (CPM) who submits a copy of current and valid certificate from the North American Registry of Midwives (NARM) that establishes their credentials as a CPM. Please make sure to check 'Other' (last option) in the checklist.
- Statement by a midwife who submits a copy of their "Certificate of Authorization" with the signature of the State Registrar. (see page 5 for "infant verification" form)
- PKU test results

Non-acceptable:

- Statement by the husband or the mother even if licensed health care professional.
- Statement from any other person that does not fall within the licensed health care professional category, the CPM, or the authorized midwife.

Sections Three and Four – Proof of residence

Acceptable

- Recent tax return
- Deed
- Current proof of insurance
- Motor vehicle registration
- W-2
- Pay stub
- State issued ID
- Photo-less ID from BMV
- Bishops letter from community
- Hunting license with signature and date
- SSN card of the child, if includes stub with current address

Non-acceptable:

- Paternity affidavit
- Voided check

PREGNANCY Verification for Out-of-Institution Births

I, _____, verify that_____

(PRINT: Health Care Provider's Name) (PRINT: Woman's Name)

(born _____), whom I saw on _____ is pregnant.

(Woman's Date of Birth) (PRINT: Visit Date)

_____ _____

Health Care Provider's Signature Date

_____

Health Care Provider's License Number

INFANT Verification for Out-of-Institution Births

I, _____, verify that _____

(PRINT: Health Care Provider's Name) (PRINT: Infant's Name)

was born alive on _____ to _____.

(Infant's Date of Birth) (PRINT: Mother's Name)

_____ _____

Health Care Provider's Signature Date

_____

Health Care Provider's License Number

AFFIDAVIT

COMPLETE ONLY IF DOING SECTION 4 - Evidence that the birth occurred outside of the mother's residence and proof of residence

BIRTH LOCATION Verification for Out-of-Institution Births

I, _____, verify that _____
(PRINT: Property Owner's Name) (PRINT: Mother's Name)

Gave birth on _____ at _____,
(Infant's Date of Birth) (Print: Street Address)

_____.
(Print: City, State, ZIP Code)

Property Owner's Signature: _____

Date: _____

Property Owner's Phone Number: _____

Before me appeared, the above-named person and signed this statement by affirmation, on this _____ day of _____ in the year _____.

Signature of Notary: _____ Seal:

My Commission Expires: _____

BIRTH PARENT WORKSHEET

FOR THE CERTIFICATE OF LIVE BIRTH

You must provide complete and accurate information to all questions on this worksheet. The information you provide will be used to create your child's birth certificate. The birth certificate is a permanent legal record that will be used by your child throughout their life for important purposes such as proof of age, citizenship, and parentage.

In addition, health researchers use this information to study and improve the health of mothers and infants. Items such as education, race, and smoking will be used for studies but will not appear on copies of your child's birth certificate (unless requested by a person listed on the certificate). State of Ohio law provides protection against the unauthorized release of health and medical information but mandates the release of identifying information from the birth certificate under public record law.

Please print clearly in black or dark blue ink. If needed, please ask hospital staff for help.

CHILD INFORMATION			
Child's Legal Name as it should appear on the birth certificate:			
First	Middle	Last	Suffix

Date of Birth:	**Sex:** ☐ Male ☐ Female ☐ Not yet determined

If multiple, this worksheet is for: ☐ First ☐ Second ☐ Third ☐ Fourth

SOCIAL SECURITY NUMBER

Do you want to request a Social Security Number for your child? ☐ **Yes** ☐ **No**

I request that the Social Security Administration assign a Social Security number to the child named on this form and authorize the State to provide the Social Security Administration with the information from this form which is needed to assign a number.

I understand that if I was married at any time during the 300 days prior to birth of this child, my spouse is presumed to be the other parent. This can only be overruled by legal documentation (court order, separation agreement, journal entry, divorce decree) stating my spouse should not be listed as a parent. If no such documentation is presented and I do not agree to list my spouse as a parent, the birth record will not be electronically transmitted to the Social Security Administration and a birth certificate will not be available for purchase.

Signature of birth parent:	**Date:**

BIRTH PARENT INFORMATION

Preferred Parentage Title (to be on your child's Birth Certificate): ☐ Mother ☐ Father ☐ Parent

Birth Parent Current Legal Name:

First	Middle	Last	Suffix

Birth Parent Name Prior to First Marriage:

First	Middle	Last	Suffix

Birth Parent Date of Birth:	**Age:**

SOCIAL SECURITY INFORMATION

Furnishing parent(s) Social Security number(s) (SSNs) is required by Federal Law, 42 USC 405c section 205c of the Social Security Act. The number(s) will be made available to state and local social services agencies to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance. The SSN is also collected as authorized by Ohio law to be used for public health purposes.

What is your Social Security number? If you do not have a Social Security number, mark "None."

			-			-					☐ None

BIRTH PARENT PLACE OF BIRTH

Birth Parent Place of Birth (Check only one and specify either state, territory or country)

_____ OR _____

☐ U.S State/Territory ☐ Foreign country

BIRTH PARENT RESIDENT ADDRESS

Residence Street Number and Name

Zip Code	**City or Town**	**County**

State	**Country**

Is current residence located inside city limits? ☐ Yes ☐ No ☐ Unknown

BIRTH PARENT MAILING ADDRESS (IF DIFFERENT FROM RESIDENCE ADDRESS)

Mailing Address Street Number and Name ☐ Check if same as resident address

Zip Code	**City or Town**	**County**
State	**Country**	

BIRTH PARENT TELEPHONE

Primary phone number ( )	**Secondary phone number** ( )
☐ I do not have a phone number where I can be contacted	**Secondary phone type:** ☐ Cell ☐ Other ☐ Relative ☐ Work

BIRTH PARENT ATTRIBUTES

What is the highest level of education you have completed? (Check only one)

☐ 8th Grade or less
☐ 9th-12th grade, no diploma
☐ High school graduate or GED completed
☐ Some college, but no degree
☐ Associate degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate or Professional Degree
☐ Decline to answer

What is your primary language (the language that you feel most comfortable speaking)?

☐ English
☐ Spanish
☐ Pennsylvania Dutch/ Deitsch/ Pennsylvania German
☐ Somali
☐ Nepali
☐ Arabic
☐ French
☐ German
☐ Other (Specify): _____

Are you of Hispanic Origin? (Check all that apply)

☐ No, not Hispanic
☐ Yes, Mexican
☐ Decline to answer
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, Other Hispanic Origin (Specify):) _____

What is your race? (Check all that apply)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native (Specify tribe): _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify): _____
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify): _____
☐ Other (Specify): _____
☐ Decline to answer

BIRTH PARENT HEALTH

Did you receive WIC (women, Infants & Children) assistance during this pregnancy?

☐ Yes ☐ No ☐ Unknown or not sure

What is your height?	**What was your weight before pregnancy?**
_____ feet _____ inches	_____ pounds

Did you smoke cigarettes during this pregnancy? ☐ Yes ☐ No

If yes, please specify the **daily** average number of cigarettes smoked **per day** for each time frame below:

Three months before pregnancy _____

First three months of pregnancy _____

Second three months of pregnancy _____

Last three months of pregnancy _____

Did you use alcohol during this pregnancy? ☐ Yes ☐ No

If yes, please specify the average number of alcoholic drinks **per day** for each time frame below:

Three months *before* pregnancy _____

First three months of pregnancy _____

Second three months of pregnancy _____

Last three months of pregnancy _____

Did you use cannabis during this pregnancy? ☐ Yes ☐ No

If yes, please specify the type of use (select all that apply):

☐ Smoking ☐ Vaping ☐ Other (Specify): _____

☐ Oils ☐ Edibles

BIRTH PARENT MARITAL STATUS – REQUIRED TO REGISTER BIRTH RECORD AND ESTABLISH PARENTAGE

Were you married at the time you conceived this child, at the time of birth, or within 300 days prior to the birth of your child?

☐ YES (continue to **SECOND PARENT INFORMATION**)

☐ YES, but I can provide legal documentation (court order, separation agreement, journal entry, or divorce decree) stating my spouse is not to be listed as the parent of my child.
(continue to **ACKNOWLEDGMENT OF PATERNITY**)
*Documentation is subject to approval by the Ohio Department of Health, Bureau of Vital Statistics

☐ YES, but I refuse to provide my spouse's name as the parent of my child. (continue to **INFORMANT**)
*Please note that under the State of Ohio law; by refusing to complete your spouse's information, your child's birth certificate will not be registered as a legal document and your child's birth information will not be electronically transmitted for a Social Security number to be issued.

☐ NO (continue to **ACKNOWLEDGMENT OF PATERNITY**)

ACKNOWLEDGMENT OF PATERNITY

Has the Acknowledgment of Paternity form been completed? That is, have you and the biological father signed an Acknowledgment of Paternity (AOP) form in the hospital.

☐ Yes, Date **signed on AOP:**

☐ No (Continue to **INFORMANT**)
*If you were not married, or if an **Acknowledgment** of Paternity form has not been completed, information about the father cannot be included on the birth certificate.

If not signed in the facility, does the parent intend to file an Acknowledgment of Paternity?

☐ Yes ☐ No ☐ Not Applicable

SECOND PARENT INFORMATION

Preferred Parentage Title (to be on your child's birth certificate): ☐ Mother ☐ Father ☐ Parent

Second Parent Current Legal Name:

First	Middle	Last	Suffix

Second Parent Name Prior to First Marriage:

First	Middle	Last	Suffix

Second Parent Date of Birth:	**Age:**

SECOND PARENT SOCIAL SECURITY INFORMATION

Furnishing parent(s) Social Security number(s) (SSNs) is required by Federal Law, 42 USC 405c section 205c of the Social Security Act. The number(s) will be made available to state and local social services agencies to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance. The SSN is also collected as authorized by Ohio law to be used for public health purposes.

What is second parent's Social Security number? If they do not have one, mark "None."

			-			-				

☐ None

SECOND PARENT PLACE OF BIRTH

Second Parent Place of Birth (Check only one and specify either state, territory or country)

_____ OR _____

☐ U.S State/Territory ☐ Foreign country

SECOND PARENT CURRENT RESIDENCE

Only complete this section if an Acknowledgment of Paternity has been signed in the facility

Residence Street Number and Name

Zip Code	**City or Town**	**County**

State	**Country**

Is current residence located inside city limits? ☐ Yes ☐ No ☐ Unknown

SECOND PARENT ATTRIBUTES

What is the highest level of education completed by the second parent? (Check only one)

- ☐ 8th Grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college, but no degree
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate or Professional Degree
- ☐ Decline to answer

Is the second parent of Hispanic origin? (Check all that apply)

- ☐ No, not Hispanic
- ☐ Yes, Mexican
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other Hispanic Origin
- ☐ Decline to answer

What is the race of the second parent? (Check all that apply)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
  (Specify tribe): _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify):
  _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify):
  _____
- ☐ Other (Specify):
  _____
- ☐ Decline to answer

INFORMANT

What is the relationship of the person providing information?

☐ Mother ☐ Father ☐ Other (Specify): _____

Informant Name:

First	Middle	Last	Suffix

Signature:	**Date:**

Dolly Parton's Imagination Library Free Book Program

I would like my child to receive a free, high quality, age-appropriate book in the mail every month from birth until they turn five years old through Dolly Parton's Imagination Library (DPIL).

I consent to allow the Dollywood Foundation, Inc. to use the information provided herein for the **sole purpose** of receiving books from DPIL. To measure the program's effectiveness DPIL may create datasets with the information provided; however, your full name, date of birth and street address will **not** be released to researchers.

You agree to review our full Terms & Conditions and Privacy Policy by visiting imaginationlibrary.com. By selecting Yes, you expressly consent to the terms set forth herein.

☐ Yes, English – Mostly English books with an occasional bilingual English/Spanish book

☐ Yes, Bilingual English/Spanish – All bilingual English/Spanish books

☐ No

Please return the completed Birth Parent Worksheet to:

FACILITY WORKSHEET FOR THE CERTIFICATE OF LIVE BIRTH

CHILD		
Child's Legal Name as it should appear on the birth certificate: First Middle Last Suffix		
Date of Birth:	**Time of Birth:** _____: _____ (24 hour) Hour Minute	**Sex:** ☐ Male ☐ Female ☐ Not yet determined

PLACE OF BIRTH	
Place where delivery occurred: ☐ Hospital ☐ Freestanding Birth Center ☐ Clinic/Doctor's Office* ☐ Other (Specify)*	☐ Home* (Intended) ☐ Home* (Not Intended) ☐ Home* (Unknown if Intended) ** If baby was delivered outside a facility, refer mother to local health department for creation of record)*
Facility Name	
Street Number and Name	

Zip Code	**City or Town**	**County**
State	**Country**	

PRENATAL

Information for the following items should come from the mother's prenatal care records, labor and delivery record, and other medical reports in the mother's chart, as well as the infant's medical record. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record, or a copy of the prenatal care information.

Mother's medical record number:

Mother's Medicaid number:

Principal source of payment for this delivery (at time of delivery)

☐ Medicaid
☐ CHAMPUS/TRICARE
☐ Private Insurance
☐ Other Government
☐ Self-Pay
☐ Unknown
☐ Other (Specify): _____

Date last normal menses began:
Enter all known parts of the date, or "99" if unknown.
Month: Day: Year:

☐ Check if no prenatal care was given.

Date of first prenatal care visit:
Enter all known parts of the date, or "99" if unknown.
Month: Day: Year:

Total number of prenatal visits for this pregnancy:

For the questions in the following section, do not include this infant. Include all live-born infants previous to this birth. For multiples include all live-born infants before this infant in the pregnancy. If completing worksheet for the first born of a set, do not include this infant.

Number of previous live births now living:

Number of previous live births now deceased:

Date of last live birth:
Enter all known parts of the date, or "99" if unknown.
Month: Day: Year:

Number of other pregnancy outcomes:

Date of last other pregnancy outcome:
Enter all known parts of the date, or "99" if unknown.
Month: Day: Year:

PREGNANCY FACTORS

Risk factors in this pregnancy (check all that apply):

Diabetes

- ☐ Pre-pregnancy
- ☐ Gestational

Hypertension

- ☐ Pre-pregnancy (chronic)
- ☐ Gestational (PIH, Pre-eclampsia)
- ☐ Eclampsia

Pregnancy Resulted from Infertility Treatment

- ☐ Fertility enhancing drugs, Artificial insemination or Intrauterine insemination
- ☐ Assisted reproductive technology (e.g. in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT))

- ☐ Previous Cesarean delivery
  How many? _____
- ☐ Previous preterm births
- ☐ Previous poor pregnancy outcome
- ☐ None of the above

Infections present and/or treated during this pregnancy (check all that apply):

- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ None of the above

Obstetric procedures:

- ☐ Successful external cephalic version
- ☐ Failed external cephalic version
- ☐ None of the above

LABOR

Information for the following items should come from the labor and delivery record, and other records in the mother's chart.

Onset of labor (check all that apply):

- ☐ Premature rupture of the membrane (prolonged, >=12 hours)
- ☐ Precipitous labor (< 3 hours)
- ☐ Prolonged labor (>=20 hours)
- ☐ None of the above

Characteristics of labor and delivery (check all that apply):

- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Antibiotics received by mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38^{0}C (100.4^{0}F)
- ☐ Steroids (Glucosteroids) for fetal lung maturation received by mother prior to delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

Mother's Weight at Delivery (pounds)

DELIVERY

Information for the following items should come from the labor and delivery record, and other records in the mother's chart. If infant is a foundling, select "Unknown" for all items in this section.

Fetal presentation at birth:

☐ Cephalic ☐ Breech ☐ Other ☐ Unknown

Final route and method of delivery:

☐ Spontaneous
☐ Forceps
☐ Vacuum
☐ Cesarean - labor attempted
☐ Cesarean - no labor attempted
☐ Unknown

Maternal morbidity (check all that apply):

☐ Maternal transfusion
☐ Third- or fourth-degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ None of the above

Was the mother transferred to this facility for maternal medical or fetal indications for delivery?

☐ Yes ☐ No ☐ Unknown If Yes, please enter the name of the facility mother transferred from:

Was the infant transferred within 24 hours of delivery?

☐ Yes ☐ No ☐ Unknown If Yes, please enter the name of the facility infant transferred to:

NEWBORN

Information for the following items should come from the labor and delivery record, other reports in the mother's chart, and the infant's medical record.

Infant medical record number:

Infant birthweight:

_____ _____ **OR** _____
Pounds Ounces Grams

APGAR score:

5 minutes: 10 minutes:

Obstetric estimation of gestation at delivery:

Completed weeks:

Plurality (number of live births and fetal losses delivered in this pregnancy):

Birth order (order of delivery for all births and fetal losses in this pregnancy):

Number of infants in this delivery born alive:

Name of prophylaxis used in child's eyes:

☐ Erythromycin / EES
☐ Ilotycin
☐ Breastmilk/ colostrum
☐ Other: _____
☐ Unknown
☐ None/Refused

Infant living at time of report?

☐ Yes ☐ No ☐ Unknown

Is infant being breastfed at discharge?

☐ Yes ☐ No ☐ Unknown

Was infant breastfed exclusively through entire stay?

☐ Yes ☐ No ☐ Unknown

NEWBORN FACTORS

Abnormal conditions of the newborn (check all that apply):

☐ Assisted ventilation required immediately after delivery
☐ Assisted ventilation required for more than 6 hours
☐ NICU admission
☐ Newborn given surfactant replacement therapy
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ None of the above

Congenital anomalies of the newborn (check all that apply):

☐ Anencephaly
☐ Cleft Lip with or without cleft palate
☐ Cleft palate alone
☐ Congenital diaphragmatic hernia
☐ Cyanotic congenital heart disease
☐ Gastroschisis
☐ Hypospadias
☐ Limb reduction defect
☐ Meningomyelocele / Spina Bifida
☐ Microcephalus
☐ Omphalocele
☐ Down syndrome karyotype pending
☐ Down syndrome karyotype confirmed
☐ Suspected chromosomal disorder karyotype pending
☐ Suspected chromosomal disorder karyotype confirmed
☐ None of the above

ATTENDANT

The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant.

Attendant's name:

Attendant's title:

☐ MD
☐ DO
☐ CNP
☐ CNM / CM
☐ Other midwife
☐ Other (specify):

Attendant NPI:

Metabolic Newborn Screening

Facility collecting the initial metabolic newborn screen

Infant's medical record number at collecting facility

Metabolic newborn screen barcode number

Infant weight in grams at time of collection

Date of newborn screen collection Time of newborn screen collection (24 hr)

MMM-dd-yyyy

Food source in the last 12 hours (Check all that apply)

- ☐ Breast
- ☐ Lactose Formula
- ☐ Soy Formula
- ☐ Tube Feeding
- ☐ NPO
- ☐ Other

Red blood cell transfusion history prior to screen (Check all that apply)

- ☐ None
- ☐ White blood transfusion
- ☐ Intrauterine transfusion
- ☐ Packed cells transfusion
- ☐ Exchange transfusion
- ☐ ECMO
- ☐ Red blood cell transfusion

Date of transfusion Time of transfusion (24 hr)

MMM-dd-yyyy

Does the infant have either of the below medical indicators (Check all that apply)

- ☐ Ambiguous genitalia
- ☐ Neither of the above
- ☐ Meconium ileus